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ABSTRACT

The purpose of this literature review is to develop a conceptual framework for counseling anorexic female clients. Literature is reviewed in the areas of the clinical picture for identifying anorexics; assessment tools for developing a therapeutic plan; cognitions and behavior change over time; and combining individual psychotherapy with family therapy. The literature reviewed agreed that disturbance in body image was a criterion for diagnosing anorexia nervosa, but some disagreement was found on the criteria of body weight, fear of gaining weight, and amenorrhea. Nine assessment tools for use in assessment of anorexic patients are reviewed. Among these nine tools are three measures specific to eating disorders; one general psychological test to measure depression; two measures to assess fear of interpersonal evaluation and social anxiety and social avoidance behavior; two interview forms of assessment for treatment planning, diagnosis, and research; and one evaluation of body image. It is recommended that anorexics seek both individual and family therapies. More research to establish facets of particular theories applicable to success in treatment of anorexics is recommended. The paper concludes with the suggestion that perhaps a new theory specifically for anorexia nervosa will evolve that addresses clinical identification, targets assessment tools, and treats the individual within her family. (ABL)

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Anorexia Nervosa

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Faculty of the College of Education
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of the Requirements for the Degree
Master of Education

Lucinda Boright

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Chapter One

Introduction

Anorexia nervosa is an eating disorder characterized by voluntary refusal to eat. Its bizarre symptoms were once rarely seen, but in the last 20 to 25 years, the incidence has increased markedly (Mitchell & Eckert, 1987). Previously an illness of upper middle class "advantaged" adolescent females, it is now noted on all social levels and has crossed into the male population (Svec, 1987).

According to New England Journal of Medicine as reported by Lehrman (1987), one in every 250 American females between the ages of 12 and 18 develops anorexia nervosa. Among these females an estimated 9% die of starvation, usually after losing half of their normal body weight, and between 2% and 5% more commit suicide. These alarming rates of incidence make anorexia nervosa important enough to study. With the dramatic rise of eating disorders over the past two decades (Shisslak, Crago, Neal, & Swain, 1987), it is probable that information gleaned through the study of anorexia nervosa will shed some light on other eating disorders.

In the last 15 years, research in the area of eating disorders has exploded (Garner & Garfinkel, 1985). Eating disorders are encountered by physicians, nurses, dietitians, psychologists, and counselors. There are many myths about eating disorders and much that is truly not understood. Anorexia nervosa has been approached from a variety of perspectives. Schlundt and Johnson (1990) point out that views range from problems arising from biological processes originating in the hypothalamus, through the culprit of slimness, to blame on the family and the kinds of early childhood experiences the family provides. Although views and approaches

vary, the common thread in anorexia includes a fear of obesity and a driving pursuit of thinness (Barile, 1983; Burckes, 1983; Caffary, 1987; Kaplan & Woodside, 1987; Sacker & Zimmer, 1987; Schlundt & Johnson, 1990).

Anorexia nervosa was described and named by William Gull (1874) though reports of self-starvation occur earlier in folk and medical literature alike (Doyen, 1982). Volumes have been written on the subject, and controversy concerning its treatment and etiology continues today. Myths about anorexia nervosa and perspectives of treatment approaches including the fear of obesity and pursuit of thinness followed by adolescents and young women need to be clarified and justified; research and agreement is requisite. The following study sheds some light on recent research, debunking anorexia's myths and clarifying perspectives of treatment approaches.

Statement of the Problem

The problem of this study is to identify characteristics of anorexic females and methods which have proven effective in therapy.

Research Questions

The questions which it is hoped this research will help to answer are as follows:

1. What is the clinical picture for identifying anorexics?
2. What are some valuable assessment tools for developing an effective therapeutic plan?
3. How do cognitions affect behavior change and maintain behavior change over the long run?
4. How does individual therapy combined with family approach offer a

comprehensive framework for conceptualizing and treating anorexia nervosa?

Purpose of the Study

The purpose of this study is to develop a conceptual framework for counseling anorexic female clients. The notion that anorexics represent the most perplexing and least cooperative group of eating disorder clients (Garner & Garfinkel, 1985), justifies the need for such a framework. Determinants for identification, along with methods of assessment in the diagnosis and a rationale for interventions, are offered in order to clarify this framework.

Assumptions

For the purpose of this study it is assumed that anorexia nervosa is a health hazard which commands earnest attention. It is also assumed that anorexia nervosa is a diagnosable and treatable disorder (American Psychiatric Association, 1987).

Delimitations

The delimitations of this study are as follows:

1. To this point most of the reported research on the subject of anorexia nervosa has been conducted with females; ergo results of this review will only be directly applicable to females.
2. Because the majority of individuals with anorexia nervosa are female, the client will be referred to as "she".
3. Most of the reported research on the treatment of anorexia nervosa has been done with a population of adolescent and young adult females, hence results of this review will not generalize to other portions of the population.

Limitations

The limitations encountered in the literature search were few. Most of the existing resources were available from Alden Library and what was not was ordered from the Veteran's Administration Medical Center's interlibrary loan (i.e., Med-Line) and through generous loan of Ohio University faculty members. With the vast amount of research available, difficulty was present narrowing the search on the topical areas of this paper. To have focused on areas other than the four mentioned below, is beyond the scope of this paper. The areas of focus were chosen for the following reasons:

1. While there is fair agreement for general identification, confusion can arise between types (i.e., restrictor and bulimic) and the eating disorder, bulimia.
2. Assessment tools are great in number, yet some tools are easier to administer, score, or comprehend. Those tools valuable to an effective therapeutic plan need to be identified.
3. Anorexia involves disturbance in food intake and energy balance along with cognitive distortions which lead to depression and anxiety. Emotional and interpersonal adjustment can be improved when cognitions, which have exacerbated the anorexia, can be replaced.
4. Anorexics benefit from individual and family therapy. The family is the anorexic's biosocial system, ergo benefit is gained when individuals and family receive treatment.

Definition of Terms

Anorexia Nervosa. The term has been in use for many years to describe a patient or client who usually presents with severe emaciation in the absence of any metabolic disease. The condition is characterized by self-starvation with profound psychiatric and physical components, among which may be 20% to 25% weight loss, amenorrhea, hyperactivity, distorted body image, electrolyte imbalances, obsession with food, and depression (Shisslak et al., 1987; Lewis, Grainger, McDowell, Gregory, & Messner, 1989).

Boundary. A concept used in structural family therapy to describe emotional barriers that protect and enhance the integrity of individuals, subsystems, and families (Minuchin, Rossman, & Baker, 1978).

Bulimia Nervosa. The term was introduced as a diagnostic category in 1980 in the third version of the American Psychiatric Association's (1987) Diagnostic and Statistical Manual (DSM III-R). It is an eating disorder which is characterized by frequent episodes of uncontrolled binge eating, followed by some form of purging to prevent weight gain, and an overconcern with body shape and weight. The purging can include self-induced vomiting, fasting, and laxative abuse (Caffary, 1987).

Bulimarexia. The term was introduced in 1976 by Baskind Lodahl and refined in 1983 by Boskind-White and White to identify bingeing and purging as a distinct eating problem in normal-weight women. They also attempted to distance the term from medical and psychoanalytic theories of causation as a learned form of behavior (Boskind-White & White, 1983). The criteria for diagnosing someone as bulimarexic, however, is vague and has considerable overlaps with many other terms (Schludt &

Johnson, 1990).

Cognitive Schema. This term is used to describe the hierarchically organized bundle of rules consisting of beliefs, action scripts, expectations, and conditional emotional responses that are linked together and are retrieved by situational and biological cues as a unit (Beck, 1976).

Countering. Once a list of distorted perceptions and cognitions is developed, the process of countering these thoughts and beliefs begins. In countering, the client is taught to recognize the error in thinking and substitute more appropriate perceptions and interpretations (McMullin, 1986).

Cross-generational Coalition. The term used for an inappropriate alliance between child and a parent who side together against a third member of a family (Nichols, 1984).

Disengagement. Minuchin's term for psychological isolation that results from overly rigid boundaries around individuals and subsystems within a family (Minuchin et al., 1978).

Double-bind. This term refers to a conflict created when a person receives contradictory messages on different levels of abstraction in an important relationship and cannot leave or comment (Nichols, 1984).

Enmeshment. The term describing a loss of autonomy due to a blurring of psychological boundaries (Minuchin et al., 1978).

Family Myths. The term used to signify a set of beliefs on a distortion of historical reality which is shared by all family members to help shape the rules that govern family functioning (Nichols, 1984).

Hierarchical Structure. Family functioning based on clear generational boundaries where parents maintain authority and control (Nichols, 1984).

Overprotective Family. Within the overprotective family there is extreme enmeshment between mother and daughter, overprotectiveness, lack of conflict resolution skills, and lack of rules for age appropriate behavior. In this type of family children experience difficulty developing independence and self-identity. The parents stifle creativity, autonomy, and achievement. Negative feelings have a strong impact on all family members and tend to be avoided whenever possible. While positive feelings are expressed, their method of expression is often not age appropriate (Schlundt & Johnson, 1990).

Perfect Family. Within the perfect family there is strong emphasis on appearance, family reputation, family identity, and success. Enmeshment, inability to express negative feelings, strong tendency toward achievement and perfectionism, and a power structure that begets submissive and unassertive behavior are the rule (Schlundt & Johnson, 1990).

Self-object. A self-object is perceived as external and to the self, yet is experienced and reacted to as part of the self. Self-object phenomenon is the basis of internalization and differentiation of a self-structure. The therapist acts as a self-object providing structure and direction to the patient (Schlundt & Johnson, 1990).

The Procedure

All articles in ERIC from January, 1983 to March, 1989 were reviewed under the headings of anorexia nervosa and eating disorders. Published information was gleaned from a search done by the library services for American Association for

Counseling and Development under the heading of anorexia nervosa. ALICE was searched under the heading of anorexia nervosa. Specific articles were obtained through the Med-Line services of the Veterans' Administration Medical Center. Workshop outlines and books were offered for review by two Ohio University faculty members. All articles and books pertaining to characteristics of the anorexic family were evaluated.

Organization of the Study

Chapter One presents an introduction to the topic of anorexia nervosa. Research questions are defined and possible implications to develop a conceptual framework for counseling anorexic female clients are stated. Assumptions are delineated. The delimitations and limitations of the study, along with definitions of key terms are presented.

Chapter Two is a review of the literature. Subheadings of the chapter are as follows: Clinical Picture for Identifying Anorexics, Assessment Tools for Developing a Therapeutic Plan, Cognitions and Behavior Change Over Time, Combining Individual Psychotherapy with Family Therapy, and Summary.

In Chapter Three the literature reported on in Chapter Two is analyzed, after a summary of Chapter One and Two. Subheadings are the same as in Chapter Two.

Chapter Four is titled Summary, Conclusions, and Recommendations. The subheadings in Chapter Four are Summary, Conclusions, and Recommendations. In it are summarized the study purpose and research questions of Chapter One, the literature review of Chapter Two, and the analysis of Chapter Three. From this are drawn the conclusions and recommendations.

Chapter Two

Literature Review

Introduction

This paper is concerned with the development of a conceptual framework for use in counseling anorexic female clients. The following types of evidence are presented in this chapter: information concerning clinical identification of anorexics, assessment tools which are valuable in developing an effective therapeutic plan, the manner in which cognitions affect behavior change and maintain behavior change over the long run, and the combination of individual and family therapy in developing a comprehensive framework for conceptualizing and treating anorexia nervosa.

Clinical Picture for Identifying Anorexics

The American Psychiatric Association (APA (1987) uses four criteria for diagnosing anorexia nervosa. First, there must be a refusal to maintain body weight over a minimal normal weight, taking age and height into consideration, with a weight loss leading to maintenance of body weight 15% below that expected; or unsuccessful expected weight gain during a period of growth, which leads to body weight being 15% below the expected weight. Second, there is an intense fear of becoming fat or gaining weight, in spite of being underweight. Third, a disturbance is present in the manner one's body weight, shape, or size is experienced (e.g., the emaciated person claims to "feel fat" or that one area of her body is "too fat" despite the fact that she is obviously underweight). Fourth, there has been an absence of at least three consecutive menstrual cycles when there is no other reason for the

absence.

In an article by Hsu (1986), a diagnosis of anorexia nervosa was presented. Hsu included most of APA's criteria, with interesting modifications. Hsu deemed the cardinal feature of anorexia was an intense fear of fatness or a relentless pursuit of thinness, which was expressed most often by willful starvation and less often by vomiting and laxative or diuretic abuse. A low body weight combined with an attempt to grade the severity of the illness by the degree of emaciation was proposed. Amenorrhea was included, but disturbance in body image was deleted. Hsu felt body image was difficult to define and might not be a characteristic feature of anorexia.

Garfinkel and Garner (1982) described the clinical picture of anorexia as a syndrome characterized by a relentless pursuit of a thin body associated with an exaggerated fear of fat or weight gain, often in spite of emaciation, and to the detriment of other psychological and physical aspects of the individual's life. Dieting, once a mere attempt to lose weight, escalated over time to feelings of mastery, control, and virtue as weight decreased. Garfinkel and Garner went on to add that they considered anorexia, in its purist sense, not to be an eating disorder, but a disorder in which the drive for thinner shape was secondary to concerns about control and/or fears of responsibility associated with achieving a mature shape.

Hilde Bruch in the Handbook of Psychotherapy for Anorexia Nervosa and Bulimia (1986) described the importance psychoanalysis played in bringing about the understanding of psychological factors to the clinical picture. She described the not yet completely departed view of anorexia as a form of conversion hysteria that

symbolically expressed repudiation of sexuality, specifically "oral impregnation" fantasies. She stated that a specific syndrome, "primary anorexia nervosa," could be differentiated from unspecific forms of psychologically determined weight loss which were secondary to other illnesses (i.e., hysteria, depression, or schizophrenia). Adolescent girls and young women from educated, prosperous households were affected with primary anorexia nervosa. Bruch discovered those affected suffered no loss of appetite and, contrarily, were preoccupied with food and eating. Refusal to eat was a pseudosolution for personality difficulties and problems of living. The clinical picture, dominated by severe malnutrition, showed deficits in the sense of self, autonomy, and identity in which somatic and psychological factors interacted closely. Rigid discipline of eating with visible weight loss gave an experience of being effective and in control. Bruch related the displayed defiance as a defense against not having a core personality and of being powerless and ineffective if the anorexic ceded. Morality and style of thinking were compared to the rigidity of early childhood concepts which had never matured to abstract thinking and self-evaluation, thus compounding the anorexic's isolation and helplessness. Bruch attributed the changing clinical picture to a "me-too" aspect in which the aura of power and superhuman discipline has infected a vast number of females who fake symptoms and want to belong to the once exclusive group who had genuine primary anorexia nervosa.

In an article by Kaplan and Woodside (1987) the clinical picture for identifying anorexics included medical complications that were related directly to the starvation state and those that were related more to bulimic behavior. The starvation-related

complications were summarized as follows:

1. Dermatological changes included dry, cracking skin. Scalp hair was often dull and thinned, yet pubic and axillary hair were usually unchanged and lanugo hair could appear on the face and neck. Fingernails and toenails were brittle, while hands and feet were prone to a dusky, bluish color due to cyanosis. Breast tissue was usually reduced. Carotene pigmentation was noted.
2. Cardiovascular changes showed bradycardia and orthostatic hypotension, which manifested in dizziness or blackouts. In addition to the aforementioned peripheral cyanosis, feet and ankles were swollen, and arrhythmias resulted in palpitations.
3. Gastrointestinal changes resulted in a general reduction of bowel activity. Reduced bowel activity may proceed to ileus, or total paralysis, of the bowel. Constipation resulted from ileus and dehydration and was accompanied by abdominal pain, bloating, and early satiety. Extreme malnutrition alluded to pancreatic insufficiency, which may have interfered with weight gain or perpetuated the anorexia.
4. Endocrine changes produced menstrual irregularities, including amenorrhea. Underweight anorexics showed hypothermia in an attempt to reduce energy expenditures.
5. Musculoskeletal changes were evidenced through generalized muscular weakness, which was secondary to destruction of muscle tissue needed for nutrients and to electrolyte abnormalities caused by nutritional imbalance and dehydration. Reduced stature and delayed bone maturation was present among

those who had manifested the illness from an early age. Binging and purging complications were as follows (Kaplan & Woodside, 1987):

- a. Dermatological changes among those who chronically vomited were evidenced by a callus on the back of the hand, due to skin irritation from the teeth during attempts to induce vomiting. Also present was irritated skin around the mouth due to contact with stomach acid, and callus formation below the ribs, due to abdominal pressure applied to facilitate vomiting.
- b. Gastrointestinal changes were severe and varied. Repeated vomiting led to parotid gland enlargement, elevated amylase in the blood, erosion of tooth enamel and dental caries, abdominal pain and hiatus hernia, pancreatitis, and/or esophageal or gastric rupture. Extensive laxative use caused bloody diarrhea and laxative dependence. The extreme result of chronic laxative abuse was a totally flaccid and nonresponsive bowel.
- c. Metabolic effects ranged from muscular weakness, through convulsions, to death. Vomiting, laxative abuse, and diuretic abuse resulted in decreased potassium levels. The loss of potassium manifested in generalized muscular weakness, palpitations, arrhythmias, and sudden death. Chaotic nutrient intake, related to binging and purging, led to amenorrhea, irregular menses, altered neurotransmitter levels, and/or reduced sensation to pain. Heart failure was associated with ipecac and convulsions were attributed to large quantities of alcohol consumed during binges.

Effects of starvation concerning cognitions and behavior, food and eating

behavior, mood and personality, sleep and libido were included in the article.

Minuchin et al. (1978) in Psychosomatic Families Anorexia Nervosa in Context contributed to the clinical picture as anorexia nervosa was described as a psychosomatic syndrome characterized by psychological and physical symptoms. They reported mortality rates of 10% to 15% and that middle class, adolescent females were generally the victims. Physical symptoms included a loss of over 25% body weight and/or amenorrhea, hyperactivity, and hyperthermia. Psychological symptoms included distorted body image, denial of hunger, fear of weight gain, pursuit of thinness, a sense of ineffectiveness, and struggle for control.

Boskind-White and White (1983) contributed the term "bulimarexia" to the clinical picture. Bulimarexia the Binge/Purge Cycle related how the bizarre, secret eating disorder dominated the lives of countless women. Obsessed by fear of fatness, women alternately binged on vast amounts of food and purged by forced vomiting, severe fasting, and/or diuretic and laxative abuse. They were described as high achievers, talented, and attractive. Unlike anorexics, who were perceived as rejecting femininity, bulimarexics were deeply committed to the feminine role. The Whites believed these women to be perfectionists, yet low in self-esteem and dependent, particularly on men. Relentless weight control was the maladaptive reaction to stress. The Whites felt that many women teeter on the edge of anorexia or bulimia during adolescence. Those enmeshed in families became anorexics; those who did not have to "show" their pain to such an extreme became bulimics. Bulimarexics, however, were more tenacious and did not exhibit the biochemical changes resulting from starvation or those psychological deficits associated with starving. Bulimareria

added an interesting facet because it called attention to the sociocultural origins of the disorder in the clinical picture.

Lewis, Grainger, McDowell, Gregory, and Messner (1989) described anorexia nervosa as a psychological disorder manifested by voluntary, self-induced starvation which centered on a need to establish control and identity. Denial and resistance were germane to the syndrome. They reported that approximately 50% of anorexics were unable to continue self-starvation and had succumbed to bingeing and purging. They went on to report that 90% of anorexics were employed; 48% reside with parents; and only 55% were able to develop a strong personal relationship and/or marry. The Manual of Psychosocial Nursing Interventions added a list of manifestations to the clinical identification picture which may include the following: emaciation with loss of subcutaneous fat and normal body contour, distorted body image, cessation of menstrual periods, weight loss of 25% body weight, incapacitating sense of ineffectiveness, hyperactivity, food binges followed by purging (i.e., fasting, vomiting, and/or overuse of laxatives; depression; constipation; dependent edema; loss of scalp hair; lanugo; intolerance of cold temperatures; bradycardia; electrolyte imbalance; inaccurate perceptions of body sensations; hypotension; alkalosis; elevated blood urea; suicidal ideation; bizarre or ritualistic behavior; preoccupation with food; manipulative behavior; abuse of laxatives and diuretics; dry, scaly skin with carotenemic hue; mild anemia; diminished libido; stunted psychosexual development; loss of bone density; body temperature decreased about 1° C.; and pimples or fine rash). The manual reported an estimated incidence of one in every 100,000 people world wide will develop anorexia annually, with a

predomination among white Western females as high as one in 200.

Schlundt and Johnson (1990) described the clinical syndrome of anorexia nervosa as dramatic and often life threatening weight loss which resulted from no metabolic disease, appeared voluntary, and was pleasing to the anorexic. Such semistarvation, severe weight loss, and techniques of purging ranged from uncomfortable to fatal. The driving forces behind anorexia and bulimia was a fear of obesity and the pursuit of thinness, yet in anorexia the fear was expressed through secondary symptoms such as the desire to maintain suboptimal body weight, body-image disturbance, and food avoidance. The fear of obesity was expressed as an obsession with being thin, was well developed, and the most prominent cognitive feature of anorexia nervosa. Body image disturbance in anorexics was manifested as a perceptual distortion where the body was perceived to be fat in spite of its emaciated appearance or as extreme dissatisfaction with size or shape of the body or certain body parts. Schlundt and Johnson noted that some anorexics were able to accurately perceive their emaciated state, yet preferred the inappropriately thin shape. Denial, a secondary symptom, was evidenced when these individuals argued that they still had several pounds to lose. Food avoidance and aversions were considered another secondary symptom in that many anorexics will eat only "diet foods" and if forced to eat "forbidden foods" will deliberately vomit. Schlundt and Johnson categorized anorexics into two types, namely "restrictor and bulimic". Restricting anorexics were capable of adhering to a strict caloric limitation which resulted in dramatic weight loss. In contrast, bulimic anorexics were not always able to maintain severe dietary restraint, ergo an alternative pattern between

semistarvation diet and binge eating followed by purging was developed. Report of 50% of women who have anorexia bingeing and purging was noted in Eating Disorders Assessment and Treatment through citation of Casper, Eckert, Halmi, Goldberg, and Davis (1980, Chapter 5).

Assessment Tools for Developing a Therapeutic Plan

The current market offers a variety of assessment methods employed for the diagnosis and treatment of anorexia nervosa. Measures designed for specific populations are more focused and yield precise information. Although assessment measures included under this subheading are by no means an exhaustive coverage, assessment tools evaluated below are used for diagnosis, treatment planning, psychological characteristics, severity of depression, degree of anxiety, social avoidance, and research.

An extensively used rating scale in the study of eating disorders for normal and anorexia nervosa populations is the Eating Attitude Test (EAT). The scale was developed by Garner and Garfinkel (1979) and appears as a 40-item or a 26-item version. The test was intended to diagnose anorexia in epidemiological studies, yet was not particularly useful because it is a measure of the psychological construct, anorexic attitude, rather than a measure of actual behavior. EAT evaluates the effect of treatment through self-report questionnaire in which the frequencies of attitudes and beliefs are rated using six-point scales. A single score is computed with cutoff sometimes used to identify eating-disordered or eating disorder prone individuals. Scores are correlated with general measures of psychopathology. Although the EAT is generally not recommended for diagnosing eating disorders, it is helpful for

identifying those at risk and for tracking the impact of treatment.

The Anorectic Attitudes Questionnaire was developed by Goldberg, Halmi, Eckert, Casper, Davis, and Roper (1980) to measure changes in attitudes of anorexic patients over time as a function of treatment. It is a self-report questionnaire administered to females diagnosed with anorexia nervosa. The format is a 63-item rating scale and scoring is through the following five subscales: (a) negative attitudes toward hospital staff, (b) fear of fat, (c) denial of illness, (d) negative attitudes toward parents, and (e) experiences hunger. To date, the Anorexic Attitudes Questionnaire has not been extensively used.

In 1983, Garner, Olmstead, and Polivy developed the Eating Disorders Inventory (EDI) as a questionnaire measure to assess psychological characteristics relevant to both anorexia and bulimia. The scale was well developed and has known reliability and validity (Garner et al., 1983). The EDI's potential uses include epidemiological studies, testing research hypotheses by comparing groups, and treatment outcome studies. The format is a 64-item rating scale and scoring is through the following eight subscales: (a) drive for thinness, (b) bulimia, (c) body dissatisfaction, (d) ineffectiveness, (e) perfectionism, (f) interpersonal distrust, (g) interoceptive awareness, and (h) maturity fears. The EDI is one of the most widely used measures in research (Schlundt & Johnson, 1990).

The Beck Depression Inventory (BDI) was developed by Beck and Beck (1972) to scale severity of depression more precisely than previously developed screening instruments. The BDI's format is a 21-item multiple choice questionnaire in which choices for each item represent different behavioral manifestations of depression. A

total score is computed as a sum of the item scores. The scores are interpreted as follows: 0-9 normal, 10-15 mild depression, 16-19 mild to moderate depression, 20-29 moderate to severe, and 30-63 severe depression. Schlundt and Johnson (1990) deem the BDI a very good instrument for measuring severity of depression and for identifying behavioral manifestations of depression for a particular patient, useful throughout the process of treating someone with an eating disorder.

The Fear and Negative Evaluations (FNE) scale, developed by Watson and Friend (1969) measures the degree of evaluative anxiety an individual has concerning social situations, interactions, and relationships. It is a 30-item true/false questionnaire in which items describe thoughts and feelings associated with social interactions. The degree of evaluative fear is calculated in a total score. The FNE contains very specific items which may be useful for planning social problem-solving therapy and for obtaining information for cognitive behavior therapy among anorexic patients.

The Social Avoidance and Distress (SAD) scale was developed by Watson and Friend (1969) as a companion measure to the FNE. The SAD is a 28-item true/false questionnaire to assess the extent to which an individual actively avoids social situations and experiences anxiety when unable to avoid social interactions. Potential uses include research, treatment planning, and treatment evaluation. The degree of avoidance and distress are calculated in a total score. The SAD may be useful for planning social problem-solving therapy and obtaining information for cognitive behavior therapy in treatment of anorexic patients.

According to Halmi (1985), the eating disorders group at the University of

Minnesota (Mitchell, Hatsukami, Eckert, and Ryle) have developed an interview form for patients with eating disorders that can be self-administered by patients. The Minnesota Eating Disorders Questionnaire is a detailed interview that is completed by the subject as an interview form which can be utilized in treatment planning, diagnosis, and research, especially for anorexic and bulimic patients. The format is a self-report questionnaire that can be keypunched into a computer data base. It covers demographic information, weight history, dieting behavior, binge-eating behavior, purging behavior, exercise, substance abuse, suicide, self-mutilation, menstrual history, marriage and pregnancy, medical and psychiatric history, and life adjustment. No scores are obtained, but from the aforementioned format the completeness of the interview is obvious and quantifies many feelings and behaviors.

Powers (Powers & Fernandez, 1984) has developed an interview form for the diagnosis and assessment of anorexia and bulimia nervosa. The questionnaire, completed by the patient, covers weight history, binge eating, purging, medical history, social history, weight profile, and autobiography. No scores are derived, but information can be coded and entered into a computer data base. This very thorough interview can be used to gather a large amount of information involving little professional time (Schlundt & Johnson, 1990).

Askevold (1975) developed an approach to the evaluation of body image called Image Marking Method. This is one of the simplest approaches available since it does not require any specialized equipment. It has been shown to differentiate eating disordered from normal individuals for testing research hypotheses and treatment outcome studies. The format involves placing a large white piece of paper

on the wall. The subject marks the width of her body at different sites and the actual width of her body is measured. Scoring employs a discrepancy index which is computed at each body site. An overall body-image distortion index is then computed by summing the individual discrepancy scores. Several studies (e.g., Pierloot & Houben, 1978; Wingate & Christie, 1978) have shown that the image making approach differentiates anorexic patients and normal controls.

Cognitions and Behavior Change Over Time

Anorexia nervosa involves a disturbance in food consumption and energy balance, along with cognitive distortions that lead to anxiety and depression (Kaplan & Woodside, 1987; Hsu, 1986; Scott & Baroffio, 1986). Such emotional and cognitive disturbances often exacerbate and maintain the disturbed patterns of behavior (Schlundt & Johnson, 1990). For behavior changes to be maintained over the long run, it is necessary to change the anorexic's cognitions.

Schlundt and Johnson (1990) consider that cognitive consequences of a behavior are the effects that the behavior has on one's ideas and thoughts. These cognitive consequences can have profound effect on subsequent behavior. Cognitive consequences as gleaned from Schlundt and Johnson (1990) are as follows: Positive consequences include the anorexic acting the way others expect her to act to receive approval, while purging and dieting allow her to see herself as a thin person who is in control. Negative consequences include a negative self-evaluation, distorted body image perception, and rules of dieting becoming increasingly more stringent.

Garfinkel and Garner (1982) feel that helping the anorexic examine her thinking is clinically useful while contributing to the understanding of how her

avoidance of food can prevail over the profound effects of starvation and social pressures to gain weight. General cognitive characteristics of avoidance behavior are relevant in understanding its resistance to extinction. Avoidance behavior can become so controlled by an internal set of rules (Corsini, 1984) that it is little affected by presence or absence of actual punishing environmental consequences. In avoidance behavior, cognitions probably come to operate autonomously (Beck & Beck, 1972). Over time a schema develops to which incoming data are shaped to fit, hence when an anorexic follows her internal rules and avoidance, she is protected against information that could modify her beliefs.

Beck (1976) suggested that various neurotic disorders are characterized by common errors in thinking, but may be distinguished in terms of "ideational content." Employing Beck's (1976) taxonomy of thinking errors, Garner and Garfinkel (1985) have linked various cognitive distortions to faulty beliefs that pertain to anorexia. Garner and Garfinkel (1985) feel the most prominent and persistent logical error is dichotomous reasoning, which involves thinking in extreme and absolute terms. Dividing food into "good" and "bad" categories, fear that gaining a pound indicates imminent obesity, oscillating between fasting and bingeing, and the inability to deviate from a rigid dietary regimen without assuming complete failure are all based on dichotomous reasoning. This reasoning permeates all aspects of the anorexic's evaluation of herself and others. Extreme attitudes are evident in fanatical pursuit of sports, school, careers, and acceptance from others (Caffary, 1987) as well as philosophies related to such concepts as happiness, morality, self-confidence, self-control, and success (Bruch, 1979). Others, particularly parents, are evaluated as

either completely perfect or intolerable monsters. Much of the dichotomous logic revolves around volitional issues of self control. Garner and Garfinkel (1985) advocate the major therapeutic task of teaching the anorexic to recognize when she is using this style of thinking, to examine the maladaptive consequences that result, and to explore the thinking's validity through calculated experimentation with "in-betweens."

Garner and Garfinkel (1985) also point out other anorexic reasoning errors including personalization, superstitious thinking, magnification, selective abstraction, and overgeneralization. Guidano and Liotti (1983) have identified additional faulty beliefs and idiosyncratic thinking styles in anorexics. For example, they suggest following Ellis and Harper's (1975) formulations, that an anorexic patient suffers from irrational beliefs related to "the dire need to be loved" and "the absolute unbearability of disappointment."

Beck, Rush, Shaw, and Emery (1979) suggest using "response prevention" to provide empirical evidence that "shoulds" (Ellis & Harper, 1975) can be ignored without dire consequences. A variation of response prevention can be effective in modification of the anorexic's compulsive behavior and accompanying conditions (e.g., "I should perform my exercise routine and eat the same safe food, or I will gain weight uncontrollably"). Beck et al. (1979) advocate slow revision of such rigid rules to expose contradictory evidence. Since successful response prevention may elicit intense anxiety, "should-resisting" experiments may be used to reinforce the slowness.

Schlundt and Johnson (1990) suggest an incompleteness to cognitive

information processing and behavior change without the closure of feedback. They note two types of feedback. First, the behaviors selected and their outcomes actually feed back onto the cognitive schemata that were employed in interpreting a situation and selecting behaviors. Emotions associated with a schema, rules for interpretation, and behavior-outcome expectancies can be altered by feedback from successful or unsuccessful performances. This type of feedback opens the possibility for changing cognition by inducing behavior change. Feedback is governed by the schema's interpretive rules, and thus could turn out to be false feedback. Schlundt and Johnson (1990) gave the example that an individual who is expected to fail, will interpret almost any outcome as failure, thus reinforcing the negative affect and pessimism she associated with that particular schema. Second is the relationship between behavior and the environment over time. Behavior is described as a cycle in which the outcome of a previous action becomes the input to the information-processing system and provides the basis for choosing the next act. As behavior changes the biological environment, it creates new cues that may invoke new schema, thus causing a shift in the cognitive basis of behavior. Schlundt and Johnson (1990) gave the example of when a behavior is met with a critical remark from another person, this criticism might invoke a totally different schema which can exert a profound influence on subsequent behavior.

The process of cognitive therapy involves a cooperative relationship between the therapist and patient (Garfinkel & Garner, 1982; Seligman, 1986; Corsini, 1984). The therapist takes a role of educator and facilitator, attempting to guide the patient into changing the way she thinks and behaves in everyday situations. The therapist

structures learning experiences to change the use of erroneous perceptions and misinterpretations and their impact on decisions (Schludt & Johnson, 1990). Once a list of distorted perceptions and cognitions is developed, the process of countering these beliefs and thoughts begins. In countering, the anorexic is taught to recognize the error in thinking and substitute more appropriate interpretations and perceptions. McMullin (1986) has compiled a comprehensive list of thought-countering strategies. Some useful therapeutic strategies for countering distorted thinking include alternative interpretation, anticatastrophic counters, coping statements, counter-attacking, label shifters, deactivating the illness belief, preventing irrational thoughts, utilitarian counters, and objective counters.

Schludt and Johnson (1990) advocate alternative interpretation in which the patient learns to stop and consider other interpretations of a situation before proceeding to the decision making stage. The patient develops a list of problem situations, evoked emotions, and interpretive beliefs. For each situation she is challenged to generate a minimum of four alternative explanations or interpretations. After the alternative interpretations have been generated, patient and therapist engage in a discussion concerning the degree to which each interpretation is logical, realistic, and supported by fact. The therapist encourages her to gather additional information in order to decide which is more realistic.

Catastrophic thinking is a common cognition distortion (Garner & Garfinkel, 1985). Development of counters to catastrophic thinking first involves generating a list of situations where the anorexic catastrophizes. The dreaded outcomes for each situation are then listed along with other possible outcomes. Likelihood of each

outcome is discussed along with positive and negative impacts (Schludt & Johnson, 1990).

Some people avoid situations when they feel the situations will be stressful or overwhelming (Lewis et al., 1989). To counter these thoughts, patient and therapist develop a set of coping statements that the patient uses to deal with these feared situations, actively utilizing patient input. For each situation, therapist and patient write a script or dialogue of thoughts she can use to anticipate any problems and utilize for effective coping. According to Schludt and Johnson (1990) the dialogue should cover perception, interpretation, decision making, and enactment in the problem situation. After the script has been rehearsed aloud with the therapist, the therapist can also model the dialogue and the patient can then repeat it back. Instructions are given for the dialogue to be practiced outside the therapy context. Another mode of rehearsal is to write various dialogues for coping with different problem situations on note cards with instructions to read through the cards several times daily.

Many negative thoughts are strongly linked to disruptive emotions such as fear, anxiety, guilt, and depression (Seligman, 1986). Counterattacking involves defeating emotionally laden thoughts by attacking them with other thoughts which are associated with strong emotion. As with the aforementioned strategies, therapist and patient list problem situations and beliefs and disruptive thoughts. Instead of merely developing rational counterthoughts, the anorexic learns to apply these counterthoughts aggressively and energetically. The more energetically the counterarrangement is delivered, the better (Schludt & Johnson, 1990). The

client's energy level can become more aroused through tensing muscles, standing, and speaking loudly and forcefully. In essence, the anorexic is taught to get mad at the unreasonable thought and to shut it down.

Many times the entire interpretation of a situation goes astray because an emotionally charged label, such as ugly, horrible, or bad, has been chosen by an individual to interpret that situation. According to Schlundt and Johnson (1990), label shifting begins when the patient is able to identify the kinds of negative words she uses to interpret situations in her life, such as bad, terrible, and/or hateful. Situations where these labels are used are then listed. Patient and therapist replace each emotional label with at least two descriptive words. In the event that accurate labels have positive emotions attached, then the client is encouraged to begin to use these words instead of negative ones.

Many anorexics come to view their eating disorder as an illness, an awful, terrible disease over which there is no control (Bruch, 1988). Initially the therapist helps the client list her beliefs concerning anorexia. The extent to which the illness model influences each belief is identified. The therapist then teaches the client a cognitive/behavioral approach for interpreting maladaptive behavior and shows how bingeing, purging, and dieting can be understood from this framework (Garner & Garfinkel, 1985). Readings and other homework can facilitate learning an alternative framework for understanding these behavioral problems. The patient learns to counter her use of the illness model with this alternative interpretation (Schlundt & Johnson, 1990).

Countering strategies often require waiting until an irrational belief occurs

before countering strategies can be delivered. Since irrational beliefs are often linked to strong emotions, this strategy forces the patient to endure negative feelings while struggling with countering the beliefs that led to the feeling. Schlundt and Johnson (1990) suggest making a list of all situations associated with strong negative emotions. Patient and therapist can develop a set of realistic rules for interpreting each situation. Beliefs should be based in fact and empirical observation as much as possible and avoid positive and negative emotional extremes. Cues or triggering events can be written on one side of a note card with rational and empirical interpretation of the situation on the other. The patient uses the note cards several times daily, like flash cards, for several weeks until the rational interpretations come easily to mind whenever the triggering event is considered. Encouragement is also given to visualize the situation while imagining response using the new interpretations.

Not all thoughts that create problems are irrational or false, yet there are more constructive ways to cope with these situations. One strategy for modifying maladaptive behaviors and cognitions is to develop counterarguments which attack the usefulness of a particular interpretation and substitute a more useful one for that situation. McMullin (1986) refers to this as utilitarian counters. According to Schlundt and Johnson (1990), the technique begins with a list of troublesome thoughts and the situations in which those thoughts occur. The therapist helps the patient focus on the desired outcome for the situation and asks her to evaluate whether each thought contributes to reaching the goal. If not, then a more goal-directed way of thinking is identified. Encouragement is given in evaluation of the

utility of her thinking and substituting goal-directed thoughts for emotion-provoking thoughts.

Since patients do not respond equally well to all counters, objective countering can be productive in some patients (Schlundt & Johnson, 1990). In objective countering, problematic thoughts and beliefs are subject to reasoned, objective, dispassionate analysis. Schlundt and Johnson (1990) advocate this approach for dealing with core irrational beliefs, which are common themes across many different situations. Core beliefs are identified, broken down into logical components, and critically analyzed. Encouragement is given to evaluate the logic of each belief and to list all reasons that can be identified for the irrationality of any given belief.

In summary, most cognitive techniques will only work if they are practiced outside the therapy session. In addition to countering strategies for maladaptive and erroneous interpretations and beliefs, several other techniques can be useful with anorexic patients. Note cards, which were previously mentioned, to be read repeatedly during the day, is one method for practicing new ways of thinking and interpreting situations. Other techniques include imagery, role playing, and homework for practicing outside the therapy session.

Combining Individual Psychotherapy with Family Therapy

The main problem in treatment of anorexics is that little can be done unless the patient admits she needs help and cooperates in the treatment. She may realize that she needs help, but her fear of becoming fat outweighs the distress and discomfort the disorder causes (Bruch, 1979, 1988; Minuchin et al., 1978; Garner & Garfinkel, 1985). Muuss (1985) feels helping her to understand that fact should be the first

step in treatment. However, this is generally difficult since the patient does not fully understand the tragic absurdity of her own eating pattern and is less than frank in expressing what she does know. Pressure from family members to eat more and seek help is resisted (Minuchin et al., 1978). Parents are initially seen as tormentors and persecutors; however, at other times, especially during recovery, she will see that they were trying to help her.

There is no agreement as to the ideal treatment modality for anorexia nervosa (Hsu, 1986; Muuss, 1985; Schlundt & Johnson, 1990). Some experts favor psychological intervention, while others place more emphasis on physical intervention. Muuss (1985) emphasizes physical intervention if the patient cannot tolerate the idea that she suffers from psychological problems. Several psychotherapies, including family therapy, are reviewed.

Hilde Bruch is one of the best known representatives of the psychodynamic approach. In an article by Doyan (1982), Bruch's 1973 data on 45 female and six male anorexics was presented. Bruch had seen these individuals either in therapy or consultation between 1942 and 1971. Contact with each anorexic ranged from a single hour to two hours a week for several years. Some patients were never hospitalized, yet others spent many months in hospitals. Bruch's diagnostic criteria included delusional disturbances in body image, disturbed perception interpretation and response to internal body sensations, and a paralyzing sense of ineffectiveness. Age of onset varied from 10 to 26 years, and anorexic behaviors disappeared about halfway through therapy (i.e., one to two years). In 60% of the cases, followup interviews were done after four or more years following onset. Bruch rated 29%

recovered on the basis of weight and subjective evaluation of social/emotional adjustment. Another 24% had gained weight, but had inadequate psychosocial adjustment. The study is noted for the psychological formulations it generated, formulations which have stimulated subsequent research into perceptual disturbances and the family's role in anorexia nervosa.

The focus of psychoanalytic treatment of anorexia is on treating the underlying personality disturbance that is causing disordered cognitions and behaviors while the development of a transference relationship is fostered. The woman who suffers from a failure to achieve individualism is encouraged to attach herself to the therapist, who functions as an empathic self-object. The patient is directed so she is able to regulate tension and learn self-control as she progresses toward self-growth and enhanced self-organization. Ideally, she is able to identify needs and feelings and develop ways of satisfying them, ergo anorexia's symptoms become unnecessary since, essentially, they are ways of dealing with the failure to develop a sense of self (Schlundt & Johnson, 1990). Current psychoanalytic treatments for eating disorders are more active and directive than classic psychoanalysis used to treat neurotic disorders (Garner & Garfinkel, 1985).

Hsu (1986) feels that most therapists incorporate some form of behavior modification during treatment of an emaciated anorexic patient. Since procedures derived from learning theory have grown in popularity, Hsu's (1986) article tells how many researchers have reported impressive results with operant conditioning. Hsu relates how researchers found that information feedback, reinforcement, and size of meal all increased caloric consumption and produced weight gain.

Techniques directed at weight gain are probably more effective than those that merely focus on eating behavior. Garfinkel and Garner (1982) found that reinforcing caloric intake may inadvertently encourage overeating and rapid weight gain may induce fear and resistance. A weight chart is employed as a vehicle for information feedback. Hsu (1986) points out that the weight chart is used by physicians who do not generally conceptualize treatment in behavioral modification terms. Patients are weighed on a daily or weekly basis and the frequency of weighing seems to have no effect on the overall amount of weight gain. Since body weight fluctuates during the day, Hsu (1986) feels that weighing is best done in the morning after the patient has used the toilet and before breakfast.

According to Garfinkel and Garner (1982), positive reinforcements for hospitalized patients contingent on weight gain are used and include increased physical and social activity and visiting privileges. Negative reinforcements, such as bed rest or isolation, are also used. Tube feedings and hyperalimentation (Schlundt & Johnson, 1990) are rarely necessary. Since patients differ in preference and response, Hsu (1986) recommends an individualized behavioral approach, yet cites literature indicating no difference in mean weekly weight gain between patients in strict and lenient operant conditioning programs. The strict program consisted of bed rest and an individualized schedule of reinforcers per .5 kg weight gain. The lenient program consisted of a contract for minimum weight gain of 1.5 kg per week, which allowed the patient to move freely about the unit; otherwise, she spent the following week in bed. Routine use of lenient structure is preferred (Schlundt & Johnson, 1990; Hsu, 1986; Garfinkel & Garner, 1982; Doyen, 1982) because it

allows the patient an element of choice.

Garfinkel and Garner (1982) feel that a large meal may induce greater consumption, yet may not encourage the development of normal eating habits. If the larger meal is not totally consumed, remaining food on the plate may signify defeat. The patient is likely to be more reassured if she finishes all her meals and is able to gain 1.5 kg per week (Hsu, 1986). Hsu (1986) added that large meals should be avoided at least during the initial stages of treatment.

Cognitive therapy concentrates on eliminating the anorexic's incorrect, irrational, and self-defeating cognitions, attitudes, and beliefs about foods, health, body image, and self-concept. Techniques and logic for cognitive interventions are described under the subheading Cognitions and Behavior Change Over Time of this chapter. Many researchers advocate a cognitive-behavioral approach (Garfinkel & Garner, 1982; Garner & Garfinkel, 1985; Hsu, 1986; Muuss, 1985; Schlundt & Johnson, 1990) that involves teaching the patient to examine the validity of her beliefs. The patient's cognitive processes, such as overgeneralization, selective abstraction, magnification, dichotomous thinking, personalization, and superstitious thinking are examined and defined, and each is systematically challenged so that her automatic thoughts may be modified.

Schlundt and Johnson (1990) consider the goal in family therapy with eating disordered patients is intervention with the entire family system in such a way that growth occurs with symptomatic behaviors of the eating disorder no longer reinforced. This model is most easily applied to the treatment of adolescents living at home (Dittmar & Bates, 1987; Hsu, 1986). In treating the older patient, friends,

children, husband, extended relatives, or anyone who is an important part of the patient's current social system may be included in the therapeutic endeavor (Schlundt & Johnson, 1990). Even if the patient is seen individually, the family approach suggests that focus of treatment is on helping the identified patient change her attitudes, feelings, and behaviors in relationship to her family and significant others in her interpersonal system (Nichols, 1984).

Family system approaches to treatment include insight oriented, structural, and strategic schools of thought (Schlundt & Johnson, 1990). These groups differ in emphasis and in the use of particular techniques while sharing basic belief in the importance of treating eating disorders within the context of family relationships and interactions. Schlundt and Johnson (1990) note that none of these schools has produced substantial treatment outcome literature documenting their methods' efficacy. Dittmar and Bates (1987) point out that, at least for younger patients, family therapy was superior to individual supportive therapy.

Todd (1985) presented a model of structural family therapy for anorexic and bulimic patients based on the work of Minuchin et al. (1978). Eight treatment principles are as follows:

1. Identification of short- and long-term goals. The first task is intervention if life-threatening behaviors are present. Family intervention strategies combined with behavioral techniques are employed to stabilize the patient's behavior while enabling the long-term goals of altering family interaction patterns.
2. Formation of the therapeutic system. The therapist joins the family to win trust and establish him/herself as teacher and leader while developing a working

relationship with the client family.

3. Challenging realities. Direct and indirect communication methods are employed to challenge the perfect family's view of reality. Particularly, the notion that the patient is sick and the family is helpless to do anything about it is dispelled. The family learns to view behaviors and relationships differently and to start analyzing how actions of one member affect the actions of all others.
4. Challenging enmeshment. Three strategies are used to dismantle enmeshment. First, rules and patterns are modified to allow each family member sufficient personal and emotional space. Second, existing subsystems within the family are strengthened. Third, the hierarchical structures within the family are strengthened. These strategies foster the development of greater independence and autonomy.
5. Challenging overprotection. Intervention is to lessen the effect of the overprotective family on the patient or any other family member whose creativity or identity is being stifled.
6. Challenging conflict avoidance. Rather than allowing the family to engage in their usual strategies for avoiding conflict, family members are forced to confront the conflict and attempt to find a resolution. Initiating conflict and teaching new communication strategies improve conflict resolution and eliminate avoidance strategies.
7. Challenging rigidity. Conflicts are induced, tasks assigned, and changes in family rules encouraged to lessen rigidity, disengagement, and enhance the family change process.

8. Challenging conflict detouring. When the eating-disordered patient is involved in triangulation with parents, the therapist intervenes to eliminate those patterns. The boundaries between parent and child are strengthened. Hazards encountered with the double blind are clarified and challenged. Often there is a need for intervention to strengthen and modify communication patterns between husband and wife.

Hedblom, Hubbard, and Anderson (1981) described a comprehensive approach to family therapy with eating disorders. The process begins with a comprehensive family assessment consisting of sessions with the entire family. Interactional patterns, role flexibility, emotional sensitivity of individual members, family supports and stresses, age appropriate behaviors, family myths and family knowledge, and understanding of the eating disorder are examined. Based on experience with 67 family therapy cases, Hedblom et al., reported that families of eating-disordered patients fit within two general categories, 65% highly emotionally reactive and 23% emotionally unresponsive. Interestingly, 12% of the families appeared to be functioning well and not contributing directly to the eating disorder.

The Hedblom et al. family therapy program was part of an inpatient unit for anorexia nervosa treatment. The goal of family therapy in this setting was to improve communication and interaction patterns and to enhance family structure in the emotionally reactive and emotionally unresponsive families. Specific problem interaction patterns identified as targets for family intervention were as follows:

1. Compliance and perfectionism. This pattern, which occurred in 75% of the patients, involved overly dependent, submissive behavior on the part of the

anorexics. They evidenced perfectionistic efforts to please parents, unquestioning obedience to most parental demands, and fear of risking parental displeasure. Social skills, interpersonal communication, and ability to appropriately express feelings were a problem.

2. Rebellion. Another 15% characterized the child as rebellious and unconcerned about her impact on the family. These emotionally charged patients often engendered hostile family conflicts.
3. Dependency. In 25% of the families, the parent was overly dependent on the child for meeting psychosocial needs.
4. Unsupportiveness. In 18% of the families, alcohol abuse or mental illness had so impaired one parent's ability to function that the parent was unable to offer any significant support.
5. Overprotective. In 8% of the families, parental interaction style was classified as overprotective. These parents attempted to control many aspects of the anorexic's life and tried to insulate her from risk or harm.
6. Blaming. In 8% of the families, parents blamed someone outside the family or one of the other family members for the anorexic's problems.

A series of principles from the Hedblom et al. family program as summarized in Schlundt and Johnson (1990) includes approaching families in a nonblaming way, setting specific treatment goals for family interventions, assuming families have done their best, encouraging family education of eating disorders, recognizing families are tired from stress, discussing the patient's progress in treatment, assuming families want help, and suggesting direct, open communication among family members.

Many therapists employ a combination of individual and family therapy in their treatment of anorexia nervosa (Hsu, 1986; Garfinkel & Garner, 1982; Garner & Garfinkel, 1985; Bruch, 1988; Schlundt & Johnson, 1990). Behavioral techniques, such as self-monitoring, goal setting, and contingency contracting, are often used in conjunction with family therapy (Schlundt & Johnson, 1990). Others employ psychodynamic insight-oriented individual therapies in conjunction with the family systems interventions (Minuchin et al., 1978). The hallmark of the family therapy approach to the treatment of anorexia is treating the entire family as the client, rather than just the anorexic patient.

Summary

In Chapter Two is presented an introduction to the literature review. Also, the following types of evidence are presented: information concerning clinical identification of anorexics, assessment tools which are valuable in developing an effective therapeutic plan, the manner in which cognitions affect behavior change and maintain behavior change over the long run, and the combination of individual and family therapy in developing a comprehensive framework for conceptualizing and treating anorexia nervosa.

In Chapter Three is presented an analysis of the literature. The research methodology is analyzed and limitations are pointed out. Other possible interpretations of the literature are made and generalizations are specified. The findings from the literature are compared and contrasted.

Chapter Three

Analysis of the Literature

Introduction

Chapter One is an introduction to the topic of anorexia nervosa. Research questions are defined, assumptions are delineated, and the delimitations and limitations of the review are presented. Key terms are defined. The procedure for the literature search is discussed.

Chapter Two is a review of the literature. Evidence is presented under different subheadings. The chapter ends with a summary.

Chapter Three presents an analysis of the literature. The research methodology is analyzed and limitations are noted. Other possible interpretations of the literature are made, and generalizations are specified. The findings from the literature are compared and contrasted under different subheadings. The chapter ends with a summary.

Clinical Picture for Identifying Anorexics

There were seven volumes (APA, 1987; Garfinkel & Garner, 1982; Bruch, 1986; Minuchin et al., 1978; Boskind-White & White, 1983; Lewis et al., 1989; Schlundt & Johnson, 1990) and two articles (Hsu, 1986; Kaplan & Woodside, 1987) reported on in this review. These books and articles presented information contributing to a clinical picture for identifying anorexics. Since the DSM III-R is the most recent standard of diagnosis "in the ongoing process of attempting to better understand mental disorders" (APA, 1987, p. xvii), components for a clinical picture will be considered in relation to the four DSM III-R diagnostic criteria.

The first component in the APA (1987) diagnostic criteria states, "Refusal to maintain body weight over a minimal normal weight for age and height, e.g., weight loss leading to maintenance of body weight 15% below that expected; or failure to make expected weight gain during period of growth, leading to body weight 15% below that expected" (p. 67). Hsu's (1986) article agreed with a low body weight, but percentages below normal weight were not given. Hsu (1986) attempted to grade the severity of anorexia by the degree of emaciation. Garfinkel and Garner's (1982) clinical picture included an emaciated body without reference to percentages below normal weight. Bruch (1986) noted malnutrition and extreme emaciation for primary anorexia nervosa, which she attributed to deficits in the sense of self-identity in which somatic and psychological factors interacted closely. Bruch (1986) made no mention of percentages or normal body weight. Kaplan and Woodside's (1987) article presented medical complications directly related to starvation, effects of starvation concerning cognitions and behavior, food and eating behavior, mood and personality, sleep, and libido, yet included neither normal body weight nor percentage requirements. Minuchin et al. (1978) stated that a loss of over 25% of body weight must be present. Boskind-White and White (1983) did not communicate a weight of 15% below minimal normal body weight in their diagnostic criteria for bulimarexia. Lewis et al. (1989) agreed with Minuchin et al. (1978) with a weight loss of 25% body weight. Schlundt and Johnson (1989) expressed life threatening weight loss sans percentages below normal weight.

The second component in the APA (1987) diagnostic criteria states, "Intense fear of gaining weight or becoming fat, even though underweight" (p. 67). Hsu's (1986)

article deemed anorexia's cardinal feature to be an intense fear of fatness or relentless pursuit of thinness, expressed most often by willful starvation and less often by purging. APA (1987) does not address or relate fear of fatness to issues of control in the anorexic. Garfinkel and Garner (1982) also agreed with APA (1987) by describing the syndrome as characterized by a relentless pursuit of a thin body associated with an exaggerated fear of fat or weight gain, despite emaciation. Garner and Garfinkel (1982) added that the anorexic's drive for thinness was secondary to concerns of control and/or fear of responsibility associated with achieving a mature shape. Bruch (1986) attributed the intense fear of gaining weight or becoming fat in primary anorexia nervosa to be psychologically determined which manifested in weight loss and feelings of control. Bruch (1986) also noted a "me-too" group of females who fake the symptoms for fear of fatness. Kaplan and Woodside (1987) mainly concern their article with biological aspects of anorexia nervosa, but agree with the aspect of an intense fear of fatness. Kaplan and Woodside (1987) point out that a gain in body weight represents a loss of control for the anorexic. Minuchin et al. (1978) include a fear of weight gain and pursuit of thinness in the clinical identification and agree with Kaplan and Woodside (1987) on the anorexic's sense of ineffectiveness and struggle for control. Boskind-White and White (1983) related that women who have bulimarexia are obsessed by a fear of fatness and the relentless weight control was a maladaptive reaction to stress. Lewis et al. (1989) alluded to a fear of gaining weight, but felt that the self-induced starvation centered on a need to establish control and identity. Schlundt and Johnson (1990) agreed with APA (1987) in that the pursuit of thinness and fear

of obesity were the driving forces behind anorexia and this fear was expressed through the secondary symptoms of suboptimal body weight.

The third component in the APA (1987) diagnostic criteria states, "Disturbance in the way in which one's body weight, size, or shape is experienced, e.g., the person claims to 'feel fat' even when emaciated, believes that one area of the body is 'too fat' even when obviously underweight" (p. 67). Hsu's (1986) article deleted a disturbance in body image, expressing that he felt body image was difficult to define and may not be a characteristic feature of anorexia. Garfinkel and Garner (1982) address body image in the context of a mature body belonging to a mature person who accepts responsibility for her life, ergo the emaciated body is not required to function as an adult. Bruch (1986) did not directly address body image, yet alluded to the notion of conversion hysteria that symbolically expressed repudiation of sexuality throughout an immature body. Kaplan and Woodside (1987) did not address body image in their article. Minuchin et al. (1978) agreed with APA (1987) and Hsu (1986) on the psychological symptom of distorted body image. Boskind-White and White (1983) did not consider the bulimarexia body image to be distorted to the extremes of APA's (1987) diagnostic criteria, but body image was associated with feelings of personal success and well-being along with society's criteria for femininity and achievement. Lewis et al. (1989) included distorted body image in their list of manifestations to the clinical picture. Schlundt and Johnson (1990) were in complete agreement with APA's (1987) diagnostic criteria for anorexia nervosa concerning body image disturbance and added that some anorexics were able to accurately perceive their emaciated states, yet preferred their inappropriately

thin shape.

The fourth component in the APA (1987) diagnostic criteria states, "In females, absence of at least three consecutive menstrual cycles when otherwise expected to occur (primary or secondary amenorrhea). (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)" Hsu (1986) included amenorrhea in his article's diagnostic criteria for anorexia. Garfinkel and Garner (1982) considered amenorrhea a physical aspect of the anorexic's life. Bruch (1986) attributed the loss of menstrual periods from malnutrition as a success in remaining immature. Kaplan and Woodside (1987) listed amenorrhea among the biological complications resulting from self-starvation. Minuchin et al. (1978) note amenorrhea as a possible physical symptom, but not a prerequisite for diagnosis. Boskind-White and White (1983) note that amenorrhea experienced by bulimarexics is generally due to environmental forces which affect them, such as the stress of daily living and/or malnourishment precipitated by purging. Lewis et al. (1989) include loss of menstrual periods among their list of clinical manifestations. Schlundt and Johnson (1990) feel that occurrence of menses is due to normal body weight fat and that amenorrhea is a consequence of weight loss and should not be singled out by the APA (1987) in the diagnostic criteria for anorexia.

It appears that the DSM III-R is not clear and/or lacking in several areas concerning diagnostic criteria. For example, the degree of emaciation displayed will depend on initial body weight, ergo an obese individual who loses a great deal of weight using the same behaviors as an anorexic will be excluded from the anorexic

category until she has lost 15% or more below the expected weight for her height and age (Schlundt & Johnson, 1990). The DSM III-R does not provide specific criteria for determining the presence of fear of weight gain and body image disturbance (Schlundt & Johnson, 1990). Literature reviewed supports the inclusion of fear of fatness and distorted body image, yet no method is provided for ascertaining if a particular patient meets these two criteria. As mentioned, the APA (1987) does not address or relate the fear of fatness to a struggle of control for the anorexic. A final problem with the DSM III-R is the omission of physical and biological manifestations for the anorexic. Kaplan and Woodside (1987) listed medical complications directly related to starvation and those directly related to bulimia in their article. The Kaplan and Woodside (1987) list coincides with a list of clinical manifestations as gleaned from Lewis et al. (1989) and clinical manifestations present in the literature reviewed. Perhaps clarity and additional diagnostic criteria will be presented and included as diagnostic features in the future.

Assessment Tools for Developing a Therapeutic Plan

The enterprise of psychological and behavioral assessment is complex, offering many alternative approaches and methods. For maximum utilization of assessment tools, the questions, which may include identification and diagnosis, distorted body image and cognitions, and treatment procedures, must be clearly defined. After questions have been defined, an assessment approach, most likely to give satisfying, useful answers is chosen. In order to yield more precise information, measures specific to eating disorders, including the EAT, EDI, and Anorexic Attitudes Questionnaire, are discussed below.

In an article by Williams, Schaefer, Shisslak, Gronwaldt, and Comerici (1986), a study comparing the EAT, the EDI, and a structured clinical interview was published. The study was to determine the accuracy of each method in detecting potential eating disorders. Subjects were 72 adolescent females who were diagnosed, using the structured interview, with 54 considered normal, nine as dieters, eight as suspected bulimics, and one as bulimic. Overall, the groups showed more difference on the EAT than the EDI. Discriminant analysis using the total EAT score along with three items from the EAT and four items from the EDI, correctly classified 86% of the subjects. The greatest number of errors was made by classifying dieters as normals. Five of the eight suspected bulimics were classified correctly. Raciti and Norcross (1987) also published an article comparing the EAT and EDI, which found both to yield similar results in the classification of college students preoccupied with weight.

A third measure specific to eating disorders reviewed in the literature was Anorectic Attitudes Questionnaire. Unlike the EAT and EDI which are psychological assessments of constructs presumed as characteristics of patients with eating disorders, the Anorectic Attitudes Questionnaire is a self-report questionnaire for measuring attitudes common in anorexia. Schlundt and Johnson (1990) advocate periodic administering of the Anorectic Attitudes Questionnaire to anorexic patients over time to note changes as a function of treatment.

Presently, an enormous variety of psychological tests are available today. As with tests specific to eating disorders, other behavioral and psychological assessments differ widely in purpose, format, and specificity (Schlundt & Johnson, 1990). The

general psychological tests, BDI, SAD, and FNE are discussed below.

In assessing a patient with an eating disorder it is important to determine whether the patient is depressed and, if so, the severity of the depression (Lewis et al., 1989; Schlundt & Johnson, 1990). The BDI can provide information throughout the process of treating an anorexic as a tool for noting the severity of depression. For example, if severe depression is noted from a score of 30-63 on the BDI, the patient may greatly benefit from a trial on anti-depressant medication (Garner & Garfinkel, 1985; Lewis et al., 1989; Schlundt & Johnson, 1990). Schlundt and Johnson (1990) deem a standard questionnaire, such as the BDI, a better way to monitor changes in affect over time than merely asking patients if they feel better.

The FNE scale is a very specific measure of interpersonal function. The FNE does not measure depression, but is deemed by Schlundt and Johnson (1990) to have more direct utility for clinical work than other highly acclaimed subscales. The items are very specific and have potential for direct material to be used in cognitive behavior therapy sessions. While at present norms for eating disordered populations have not been published, Schlundt and Johnson (1990) have found clinically that many eating disordered patients score high on the FNE scale, indication extreme concern over what others think of them. Messner and Lewis (1984) feel that the FNE is useful for research, treatment planning, and treatment evaluation.

While the FNE measures fear of interpersonal evaluation, the SAD, designed as a companion measure, assesses social anxiety and social avoidance behavior. According to Schlundt and Johnson (1990), many eating disordered patients show a high fear of negative evaluation, yet only some experience high levels of social

anxiety and actively avoid social situations. The FNE and SAD used in conjunction will yield a fairly specific assessment of how the anorexic thinks, feels, and behaves with respect to social interactions. Both the FNE and SAD contain very specific items which could be used directly in cognitive behavior therapy.

To this point a variety of questionnaires, namely the EAT, EDI, Anorectic Attitudes Questionnaire, BID, SAD, and FNE, have been covered in a manner to prove useful in the assessment and treatment of eating disorders. Questionnaires tend to be very specific, measuring only well-focused constructs and behaviors. Questionnaires are generally quantified, yielding a number or profile of numbers as the end product. The usefulness of questionnaires include high reliability, minimization of faking, and comparison of individuals in quantitative dimensions. Yet, psychometric questionnaires do not provide the speed and ease in gathering the large body of behavioral and psychological information in a short period of time as an interview. The interview forms of the Minnesota Eating Disorders Questionnaire and the South Florida Eating Disorders Questionnaire are compared below.

Both the Minnesota Eating Disorders Questionnaire and the South Florida Eating Disorders Questionnaire were designed for treatment planning, diagnosis, and research among anorexic and bulimic populations. Both cover weight history, binge eating, purging, medical and psychological history, and weight profile. No scores are obtained from either measure, yet data from the Minnesota Eating Disorders Questionnaire can be directly entered by the subject into a computer database while completing the interview form, yet the South Florida Eating Disorders Questionnaire requires coding of data by a clinician before entering findings into a computer data

base. The Minnesota Eating Disorders Questionnaire gathers information on substance abuse, self-mutilation, and suicide, where the South Florida Eating Disorders Questionnaire does not. These two base-line assessment instruments are excellent research and treatment tools due to the facilitation of data and ease of entrance into computer data bases (Schlundt & Johnson, 1990).

One of the simplest approaches available for estimating perceived size is the Image-Marking Method (Garner & Garfinkel, 1985; Garfinkel and Garner, 1982; Schlundt & Johnson, 1990). No special equipment is needed; the subject stands before a sheet of paper mounted on the wall and is asked to imagine that she is facing a mirror. With pencil in hand, she is instructed to mark the place where she "sees" points which correspond to widths of specific body regions. Garfinkel and Garner (1982) point out that Askevold (1975) recommended this method despite the absence of adequate control groups and statistical analysis of results. Two studies have shown that the image marking technique differentiated between anorexic patients and controls (Pierloot & Houlen, 1978; Wingate & Christie, 1978). Garfinkel and Garner (1982) add that in the Wingate and Christie (1978) study, lower ego strength (as measured by the E scale of the MMPI) was related to the anorexic's overestimation tendency. This relationship was confirmed by a study done by Scott and Baroffio (1986). Potential uses for the Image Marking Method include testing research hypotheses and treatment outcome studies (Schlundt & Johnson, 1990).

In summary, assessment tools discussed, compared, and contrasted were the EDI, EAT, Anorectic Attitude Questionnaire, BDI, SAD, FNE, Minnesota Eating

Disorders Questionnaire, South Florida Eating Disorders Questionnaire, and Image Marking Method. According to Schlundt and Johnson (1990), the task lies in choosing which assessment instruments, out of the many available, to use with which patients. Many sources (Seligman, 1986; Hedblom et al., 1981; Casper et al., 1980; Schlundt & Johnson, 1990) recommend employing at least a minimal battery of measures so that information concerning an individual's eating disorder is not limited to information gathered in clinical interviews.

Cognitions and Behavior Change Over Time

Clinicians have borrowed concepts and methods of modern cognitive science and applied these to the understanding of how cognitive processes contribute to emotional and behavioral disorders (Carver & Scheier, 1988). Schlundt and Johnson (1990) note that all information-processing activities occur within an environmental and biological context. Information processing is conceived of as moving through a series of stages which intervene between the input of sensory information and output of behavioral response. Events within each stage are based on output from a previous stage and results are passed along to the next stage. The literature reviewed under this subheading in Chapter Two is compared and contrasted according to Schlundt and Johnson's (1990) information processing model considering the stages of perceptual processing, interpretation, decision making, response execution, and feedback.

Nine volumes in the literature reviewed the stages of perceptual processing. Garfinkel and Garner (1982) feel that perceptual processing is affected by the profound effects of starvation. Beck (1976) suggested that errors in thinking are

related to faulty beliefs which govern the anorexic's life. Bruch (1979) noted that the anorexic's perceptual process was jaded by extreme attitudes, while Seligman (1986) relates negative thoughts to the disruptive emotions of fear, anxiety, guilt, and depression. Corsini (1984) noted the presence of an internal set of rules in the anorexic to protect her against information that might modify her beliefs.

Interpretation occurs after cues from the biological and external environment have been perceived and identified. The interpretive stage is important in the analysis of modification of maladaptive behavior patterns. Most cognitive therapists focus on how anorexics link erroneous beliefs to specific situations and then engage in behaviors predicted on their misinterpretations. Beck's (1976) taxonomy of thinking errors can be linked to the faulty beliefs that pertain to anorexia, such as the anorexic dividing food into "good" and "bad" categories and fear that gaining a pound indicates imminent obesity. Garner and Garfinkel (1985) feel the most prominent and persistent error in interpretation is dichotomous reasoning, which involves thinking in extreme and absolute terms. Bruch (1979) notes the anorexic evaluating her parents as completely perfect or intolerable monsters. Ellis and Harper (1975) suggest that the anorexic suffers from irrational beliefs related to "the dire need to be loved" and "the absolute unbearability of disappointment."

The anorexic assumes her decision will yield best results in terms of obtaining positive consequences, and avoid negative consequences. Corsini (1984) noted that avoidance can become so controlled by the anorexic's internal set of rules that it is little affected by actual negative consequences. Beck (1972) pointed out that in avoidance behavior, cognitions operate autonomously, so much to the point with

anorexics that their internal rules and avoidance protect them against information which could modify their beliefs. Schlundt and Johnson (1990) consider positive consequences to include approval from others and a self-concept of a thin person, who is in control. They consider negative consequences to include distorted body-image, negative self-evaluation, and increasingly stringent dieting rules. Lewis et al. (1989) added that the anorexic avoids situations which she feels will be stressful or overwhelming. Beck (1972), Corsini (1984), and Lewis et al. (1989) did not comment on positive consequences.

Once the decision has been made, a response is executed into a sequence of overt behaviors. Schlundt and Johnson (1990) noted that cognitive consequences have profound effect on subsequent behavior. Garner and Garfinkel (1985) as well as Caffary (1987) discussed how extreme attitudes are evident in the fanatical pursuit of sports, school, careers, and acceptance from others. Beck (1972), Corsini (1984), Lewis et al. (1989), and Bruch (1979) did not comment on response execution, however Beck et al. (1979) and Ellis and Harper (1975) suggested "response prevention" in which "shoulds" can be ignored without dire consequences.

Schlundt and Johnson (1990) note two types of feedback. First, the chosen behaviors and their outcomes feed back onto the cognitive schemata that were employed during interpretation and behavior selection. The second is the relationship between behavior and the environment over time. These feedbacks are therapeutically discussed below. McMullin (1986) posed nine thought countering strategies for countering the anorexic's distorted thinking. Garner and Garfinkel (1985) discussed catastrophic thinking, a common cognition distortion. They

advocated countering catastrophic thinking through a list of catastrophic situations from which likelihood of each outcome is discussed. Lewis et al. (1989) also suggested a list of stressful situations countered by patient and therapist through a set of coping statements. Sligman (1986) employed the list of problem situations, but suggested the anorexic apply aggression and energy to the counterargument, getting mad at the unreasonable thought and shutting it down. Schlundt and Johnson (1990) outlined a system for label shifting feedback with realistic rules in the list of problem situations. Bruch (1988) used a list of the anorexic's beliefs concerning her anorexia and taught the patient to interpret maladaptive behavior through a cognitive/behavioral approach. Bruch (1988) did not employ any form of the word counter in discussing therapeutic feedback. Instead, Bruch focused on underlying problems which have thwarted the development of a positive self-concept. Bruch (1988) insisted that the anorexic needed to rediscover her self. Schlundt and Johnson (1990), McMullin (1986), Garner and Garfinkel (1985), Seligman (1986), Lewis et al. (1989), and Bruch (1988) agreed that positive cognitive feedback will work over time only when practiced outside the therapy session.

Combining Individual Psychotherapy With Family Therapy

There are literally hundreds of different approaches to psychotherapy currently being practiced in treatment of anorexia nervosa. In all approaches a theory of human behavior, experience, or emotion had been employed before one or more methods was chosen to resolve the anorexic's difficulties. Among the seven volumes and three articles reviewed in the literature under the above subheading, approaches are compared and contrasted in relation to specific conceptualizations of anorexia

nervosa and selected methods of treatment.

Bruch (1979, 1988), Minuchin et al. (1987), and Garner and Garfinkel (1985) felt that the anorexic must realize she needs help and acknowledge her fear of fatness. Muuss (1985) agreed, but pointed out that the anorexic's logic did not facilitate admission and awareness. In Doyan's (1982) article, Bruch conceptualized anorexia through body image disturbance, disturbance interpreting body sensations, and the individual's sense of ineffectiveness. Other literature reviewed revealed diagnostic criteria which may be considered as specific conceptualizations, but to identify these characteristics is beyond the scope of this subheading.

Bruch (1979, 1988) advocated a psychoanalytic approach for treatment of anorexics by exposing the underlying personality disturbance through transference relationship. Doyan's (1982) article reported on data compiled by Bruch in 1973, which pointed to perceptual disturbances of the patient and the family's role in anorexia. Bruch's (1988) psychoanalytic method directed therapists to help the patient to rediscover herself. Garner and Garfinkel (1985) and Schlundt and Johnson (1990) advocated more action and direction for psychoanalytic treatments. Hsu's (1986) article made no mention of psychoanalytic intervention while Muuss's (1985) article emphasized physical intervention for the patient who cannot tolerate the ideas that she suffers from psychological problems.

Hsu (1986) felt that behavior modification in some form is included in treatment. Hsu reported impressive results with operant conditioning and that techniques directed at weight gain were more effective than techniques focused on eating behavior. Garfinkel and Garner (1982) stated that reinforcing caloric intake

inadvertently encouraged overeating. Hsu (1986) recommended an individualized behavioral approach of either strict or lenient operant conditioning programs. Schlundt and Johnson (1990), Hsu (1986), Garfinkel and Garner (1982), and Doyan (1982) preferred routine use of lenient structure for behavior modification. Garfinkel and Garner (1982) and Hsu (1986) agreed on smaller meals during treatment which, when finished, rewarded the patient with success. Bruch (1988) stated that behavior modification was only useful with very young patients.

Many researchers (Garfinkel & Garner, 1982; Garner & Garfinkel, 1985; Hsu, 1986; Muuss, 1985; Schlundt & Johnson, 1990) concentrated on the cognitive-behavioral approach to therapy where the anorexic is taught to examine the validity of her beliefs. Although Bruch (1988) does not use the terminology "cognitive-behavioral", her views concerning disturbed concepts of food, body, and self, and her procedure for rediscovering the self strongly resemble a cognitive-behavioral model.

Schlundt and Johnson (1990), Bruch (1988), Garner and Garfinkel (1985) and Minuchin et al. (1978) considered a goal in family therapy with anorexic patients to be an intervention with the family in such a way that growth occurs and the behaviors symptomatic of the disease are no longer reinforced. Schlundt and Johnson (1990) noted that among insight-oriented, structural, and strategic schools of family therapy, there is no substantial treatment outcome data to support exclusive use of one therapy. In articles by Dittmar and Bates (1987) and Hsu (1986), family intervention success occurred most often with adolescents living at home. Nichols (1984) agreed with the common goal for family therapy and included significant others outside the nuclear family for therapeutic treatment.

Based on the work of Minuchin et al. (1978), Todd (1985) presented a model of structural family therapy. Interestingly, Todd (1985) associated structural family therapy with Minuchin et al. (1978), yet examination of Psychosomatic Families Anorexia Nervosa in Context revealed a combination of the linear model, which focuses on the individual and the systems model, looking at the individual in context with her family. Hedblom et al. (1981) described a comprehensive approach to treatment.

The premise behind Todd (1985) and Hedblom et al. (1981) appeared to coincide and goals of improved communication and interaction patterns were common, yet means of achieving the goals differed. Both approaches identified goals initially and a caring, working relation was developed. Todd's (1985) model challenged and confronted realities, enmeshment, overprotection, conflict avoidance and detouring, and rigidity. The Hedblom et al. (1981) approach acknowledged the components of dysfunction in the anorexic family, yet regarded the family in a more positive light and less challenging manner. Principles from the Hedblom et al. (1981) family program included nonblaming approach; that families have done their best and are tired from stress, assuming they want help; encouraging family education of eating disorders; discussing programs during treatment; and encouraging open communication among family members (Schlundt & Johnson, 1990). Todd (1985) presented eight treatment principles: identifying short- and long-term goals, forming the therapeutic system, challenging realities, challenging enmeshment, challenging overprotection, challenging rigidity, challenging conflict avoidance, and challenging conflict detouring. Hedblom et al. (1981) presented six

components targeted for family intervention: compliance and perfectionism, rebellion, dependency, unsupportiveness, overprotectiveness, and blaming. The challenges presented in Todd's treatment principles overlap Hedblom et al.'s targeted components for family intervention. Todd's proposed challenges of conflict avoidance and rigidity overlap with the Hedblom et al. pattern of compliance and perfectionism. The challenge of reality overlaps unsupportiveness and rebellion intervention. The challenges of enmeshment and overprotection overlap interventions aimed at dependency and overprotectiveness. The challenges of conflict avoidance and detouring overlap the intervention component of blaming. Both discussed the use of cognitive interventions in conjunction with family therapy.

Summary

Most published evidence included restricting and/or purging behaviors to produce weight loss in the anorexic. The DSM III-R, which is the most recent standard of diagnosis, was unclear or lacking in areas concerning the degree of emaciation, behavior criteria for weight loss, specific criteria for determining the presence of fear of weight gain and body image disturbance, and physical and biological manifestations for the anorexic. Literature reviewed indicated a need for clarity and additional diagnostic criteria to be included in the standard for diagnosis.

According to the literature review, the task concerning assessment tools lies in choosing a specific tool, out of the many available, to use with specific patients. Nine assessment tools were discussed, compared, and contrasted. Indicated in the literature is employment of a minimal battery of measures so that information is not limited.

Analysis of the literature indicated that a cognitive behavioral approach combined with family therapy would produce positive behavior change over time. Theories overlap and there is insufficient data, at present, to conclude that any particular theory or framework is clearly superior to another. However, there is agreement for practicing new cognitions and behaviors outside therapy sessions.

Chapter Four is titled Summary, Conclusions, and Recommendations. In it is described the study purpose, a summary of the literature review of Chapter Two, and the analysis of Chapter Three. On the basis of the summary, conclusions are drawn.

Chapter Four

Summary, Conclusions, and Recommendations

Introduction

This chapter is divided into four sections. The first section provides an introduction. The second section summarizes Chapter One, Chapter Two, and Chapter Three. The second section draws conclusions for each of the sub-problems. The last section deals with recommendations for action and research.

Summary

The problem of this study is to identify characteristics of anorexic females and methods which have proven effective in therapy. In order to answer the above problem, the following questions are developed in Chapter One:

1. What is the clinical picture for identifying anorexics?
2. What are some valuable assessment tools for developing an effective therapeutic plan?
3. How do cognitions affect behavior change and maintain behavior change over the long run?
4. How does individual therapy combined with family approach offer a comprehensive framework for conceptualizing and treating anorexia nervosa?

The purpose of this study is to develop a conceptual framework for counseling anorexic female clients. The notion that anorexics present the most perplexing and least cooperative group of eating disorder clients (Garner & Garfinkel, 1985) justifies the need for such a framework.

Chapter Two is a review of the literature. Literature is reviewed under

subheadings Clinical Picture for Identifying Anorexics, Assessment Tools for Developing a Therapeutic Plan, Cognitions and Behavior Change Over Time, and Combining Individual Psychotherapy with Family Therapy.

The APA (1987) lists four criteria for diagnosing anorexia nervosa. The criteria include body weight, fear of gaining weight, disturbance in body image, and amenorrhea. Seven volumes and two articles were reviewed. All literature reviewed agreed with a fear of gaining weight. All literature reviewed, with exception of one article, agreed with a disturbance in body image. The literature reviewed commented on body weight, but percentages of weight loss or expected weight gain varied. Four volumes and one article agreed with the clinical requirement for diagnosis of amenorrhea. Three volumes and one article stated that amenorrhea was a complication of starvation. One article separated medical complications that were directly related to starvation from those directly related to bulimic behavior. One volume described physical complications due to anorexic behavior. Four volumes discussed issues for control and identity in the anorexic's life. Three of the volumes and both articles made no mention of issues of control and identity.

While there are a vast number of general psychological tests that might be useful in the assessment of anorexic patients, nine assessment tools were reviewed. Three were measures specific to eating disorders, with two in particular for anorexia nervosa. One general psychological test was to measure the severity of depression of the anorexic, which yields clear implications for treatment approaches. Two other psychological tests reviewed were companion measures, one to assess fear of interpersonal evaluation and the other to assess social anxiety and social avoidance

behavior. Two interview forms of assessment were reviewed. Both interviews had potential uses in the areas of treatment planning, diagnosis, and research. One evaluation of body image was reviewed. Among the overwhelming number of assessment tools available, time and cost are variables in the decision for choosing tests.

Anorexia nervosa involves a disturbance in food consumption and energy balance, along with cognitive distortions which lead to anxiety and depression. Nine volumes and three articles were reviewed which describe the anorexic's cognitive schema. All sources advocated some form of cognitive therapy. Four volumes and one article offered cognitive therapy techniques. Five volumes described specific countering strategies. All sources reviewed agreed that the anorexic's emotional and cognitive disturbances sustained her disturbed behavior patterns and for behavior changes to be maintained over the long run, her cognitions must be changed.

Individual psychotherapy combined with family therapy offers a comprehensive framework for conceptualizing and treating anorexia nervosa. Five volumes and seven articles were reviewed. One volume and one article advocated psychoanalytic theory and reported a 29% recovery rate in one study (Doyan, 1982) where this individual intervention was employed. Two articles and two volumes discussed individual behavior therapy and offered no information concerning recovery rate. Three volumes and two articles discussed individual interventions with cognitive therapy and offered no information concerning recovery rate. Four volumes and four articles discussed interventions with the anorexic family. One article advocated structural family therapy and offered a list of treatment principles. One article

offered a comprehensive family approach along with a list of identified targets for intervention. Literally hundreds of different approaches to psychotherapy are currently being practiced.

Literature reviewed, compared, and contrasted revealed the following:

1. There is an abundance of recent credible published literature available to identify characteristics of anorexic females.
2. The current market offers a variety of assessment tools focused on the anorexic population.
3. Emotional and cognitive disturbances exacerbate and maintain the anorexic's disturbed behavior patterns.
4. Existing data concerning individual therapies and family approaches is not only vast, but varying.

Conclusions

This research project is concerned with characteristics for the identification of female anorexics and methods which have proven effective in therapy. Four sub-questions have been established. The questions and the answers, as found in this review, follow.

1. What is the clinical picture for identifying anorexics?
 - a. Anorexics voluntarily refuse to maintain a minimal body weight for age and height. They are anywhere from 15% to 25% below their minimal body weight and have achieved this through self-starvation and/or purging, ergo malnutrition is present.
 - b. Anorexics have an intense fear of gaining weight or becoming fat and any

weight gain represents a loss of control.

- c. Anorexics exhibit disturbance in body image.
 - d. Amenorrhea may or may not be present.
 - e. Observable complications may or may not include hyperactivity, laxative dependence, depression, loss of scalp hair, lanugo, suicidal ideation, intolerance of cold temperatures, dry scaly skin with carotenemic hue, mild anemia, stunted psychosocial development, loss of bone density, and manipulative behavior.
2. What are some valuable assessment tools for developing an effective therapeutic plan?
- a. For measures specific to eating disorders, the EAT is a psychological measure of anorexic-like attitudes and beliefs, the Anorectic Attitudes Questionnaire measures attitudes common in anorexia nervosa, and the EDI is a psychological assessment of constructs presumed to be characteristics of patients with eating disorders.
 - b. For general psychological tests, the BDI is a psychological assessment of the severity of depression, the FNE is a questionnaire to assess the extent to which social interactions are anticipated to have negative outcomes or negative evaluations from others, the SAD is a questionnaire to assess the extent to which social situations are actively avoided and the extent of anxiety experienced when social interactions are unavoidable.
 - c. For interviews, the Minnesota Eating Disorders Questionnaire is a detailed interview completed by the anorexic and the South Florida Eating Disorders

Questionnaire is also completed by the anorexic.

- d. For a method of assessing body image, the Image Marking Method is a psychological measure of body size misperception.
3. How do cognitions affect behavior change and maintain behavior change over the long run?
 - a. Emotional and cognitive disturbances exacerbate and maintain the anorexic's disturbed behavior pattern.
 - b. Cognitive behavioral therapy and/or countering techniques for behavior change are employed therapeutically and then practiced outside the therapy sessions.
4. How does individual therapy combined with family approach offer a comprehensive framework for conceptualizing and treating anorexia nervosa?
 - a. Because the anorexic is a product of and is influenced through relationships and interactions with her family, the anorexic is the identified patient and her family is considered the anorexic family.
 - b. In combination, the anorexic is treated individually while components of family dysfunction are targeted, confronted, and therapeutically treated within a family context.

Recommendations

The results of this review will be applicable to psychologists and counselors working with an anorexic population. Therapists working in in-patient and out-patient settings may be interested in implementing the five diagnostic criteria or augmenting their current diagnostic criteria with the recommendations offered in

this review. Anorexics desiring recovery should note the recommendation of the first two steps they must take in their recovery process.

The most important recommendation is that anorexics should be identified through five criteria. First is a voluntary refusal to maintain minimal body weight. Second is an intense fear of gaining weight which should be linked to issues of control. Third is a disturbance in body image. Fourth is that amenorrhea may or may not be present. Fifth includes a list of observable physical and psychological complications which may or may not be present.

There are four recommendations concerning assessment tools. First, a measure specific to eating disorders should be employed in order to separate the anorexic from other eating disorders and normal populations. Second, a general psychological test should be employed to detect degrees of depression and anticipated negative outcomes experienced by anorexics. Third, interviews should be administered to anorexics to glean information specific to a treatment and research. Fourth, the extent of body image disturbance should be ascertained.

There are two recommendations for anorexics themselves. First the anorexic should seek individual therapy. Second, the anorexic should seek family therapy. The analysis of Bruch (1988), Minuchin et al. (1978), Garner and Garfinkel (1985), and Schlundt and Johnson (1990) suggest that a comprehensive framework for treatment cannot be developed without the combination of individual and family therapies.

More research should be done to establish facets of particular theories applicable to success in treatment of anorexics. Currently individual and family

theories leave some areas unanswered and overlap in treatment focus of others.

Perhaps a new theory specifically for anorexia nervosa will evolve – one that addresses the clinical identification, targets specific assessment tools, and treats the individual within her family.

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